IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7005 1160 0000 1506 9414

October 7, 2008

Debbie Freeze, Administrator
Lewiston Rehabilitation & Care Center
3315 Eighth Street
Lewiston, ID 83501

Provider #: 135021

Dear Ms. Freeze:

On **September 24, 2008**, a Complaint Investigation and State Licensure survey was conducted at Lewiston Rehabilitation & Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 20, 2008**. Failure to

submit an acceptable PoC by **October 20, 2008**, may result in the imposition of civil monetary penalties by **November 10, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **October 29, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 29, 2008**. A change in the seriousness of the deficiencies on **October 29, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 29, 2008** includes the following:

Denial of payment for new admissions effective **December 24, 2008**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 24, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 24, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **October 20, 2008**. If your request for informal dispute resolution is received after **October 20, 2008**, the request will not be granted. An incomplète informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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October 7, 2008

Debbie Freeze, Administrator
Lewiston Rehabilitation & Care Center
3315 Eighth Street
Lewiston, ID 83501

Provider #: 135021

Dear Ms. Freeze:

On **September 24, 2008**, a Complaint Investigation and State Licensure was conducted at Lewiston Rehabilitation & Care Center. Marcia Key, R.N. and David Scott, R.N. conducted the complaint investigation. Fifteen and one-half survey hours were required to complete this investigation.

The investigation included review of the identified resident's facility record, as well as the hospital record from July 9 through 22, 2008.

Nine residents and four staff members were interviewed including the Director and Assistant Director of Nursing, a Resident Care Manager and the therapy department manager.

The facility's Resident Council minutes and Incident/Accident reports were reviewed from June 1 through September 15, 2008.

Upon entry to the facility, the regional Ombudsman was called. She indicated she had not received any formal grievances against the facility in the recent past. She spoke with the surveyor later and stated that the last formal complaint against the facility was in January 2008.

The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003715

ALLEGATION #1:

The complainant stated an identified resident's oxygen saturation levels were inadequate when receiving oxygen via a compressor in the resident's room. The certified nurse aides would have the resident take several deep breaths or cough repeatedly to get the saturation levels within normal limits.

The complainant also stated that staff did not record the identified resident's vital signs when outside of normal limits. The aides would return to the resident's room to retake the vital signs, then only record readings that were within normal limits.

FINDINGS:

The identified resident's record documented the resident's respiratory status was closely monitored. She required oxygen per nasal cannula at three liters per minute on a continuous basis. She was stable on the oxygen, as evidenced by her oxygen saturation levels that were within acceptable range for her. The practice of instructing the resident to deep breathe and cough is an appropriate practice in order to determine if the saturation levels would rise and to assist the resident to receive optimal benefit from the oxygen administered.

The resident's record documented vital signs that were not always within "normal limits." The staff monitored her vital signs and contacted the treating physician as needed.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident required medication to be crushed, however, the facility refused to crush the medications and instead administered the medications whole in applesauce.

FINDINGS:

The identified resident's record documented the resident was able to eat a mechanically soft diet without difficulty. She had a diagnosis of esophageal reflux disease with strictures, which required dilatation in the past.

The Director and Assistant Director of Nursing indicated the resident requested the staff to dissolve the large pills in warm water. The resident was able to swallow the small pills without difficulty. They also indicated the nurses were aware of the resident's request and administered the pills in this manner as feasible. In addition, the facility made every attempt to provide continuity of care by ensuring, to the extent possible, that the same nurses administered medications to the residents.

There was no physician order directing the staff to crush the resident's medications.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the staff sometimes took up to 30 minutes to answer call lights, would leave the identified resident in "uncomfortable" straight back chairs and a wheelchair for long periods and would leave the resident unattended on the toilet for up to 30 minutes.

The complainant did not identify any specific times or dates.

FINDINGS:

The identified resident was no longer in the facility so could not be observed. Her care plan, dated May 23, 2008, directed that she was not to sit in a chair for more than 20-30 minutes at a time.

Nine random residents stated they had no concerns about call lights not being answered timely or about getting assistance during toileting.

The Resident Council minutes did not identify any concerns regarding call lights not being answered in a timely manner. The Resident Council minutes, dated June 23, 2008, documented ten residents attended. The comments expressed were, "Everything is going well... All the staff do a good job." The minutes, dated September 15, 2008, documented 14 residents attended. The comment expressed was, "Everyone (is) doing (a) really good job."

During the investigation survey, staff members were observed to be answering call lights in a timely manner.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the identified resident experienced burning during urination in June 2008. The staff was aware of this; however, a urinalysis was not obtained until ten days later. Once the laboratory results were known, it was three to four days before the resident was started on antibiotic therapy. The antibiotic was ineffective since the organism was not sensitive to the medication.

FINDINGS:

The identified resident's record revealed the resident started to experience signs and symptoms of a urinary tract infection on June 11, 2008. The physician was immediately contacted and ordered a urinalysis be obtained and the antibiotic, Cipro, to be administered for seven days. The resident's record documented the urinalysis was obtained and the resident was started on the medication on June 11, 2008. On June 12, 2008, the resident's signs and symptoms of the urinary tract infection resolved and she had no further urinary problems during her stay in the facility.

The facility received the results of the urine culture that documented the organism strain was resistant to the antibiotic, Cipro. The facility did not receive an order to start a different antibiotic, Keflex, which the organism was sensitive to, until June 20, 2008.

The Director of Nursing indicated that during the period of June 11 through approximately June 18, the resident's anemia worsened and the physician and staff was treating this more critical problem. The urine culture report was inadvertently overlooked.

The Director of Nursing also stated the laboratory routinely sends all laboratory reports to the facility and to physicians' offices. During the investigation survey, the laboratory faxed the surveyors documented evidence that on June 13, 2008, the laboratory had faxed the urine culture report to the physician.

The treating physician was interviewed via telephone. She reviewed her office records and stated that, to her knowledge, she had not received the faxed laboratory report.

Although the facility acted promptly after the resident started to experience the signs and symptoms of the urinary tract infection and immediately started the antibiotic, the facility did not ensure the physician received the urine culture report on June 13, 2008, or ensure the physician was aware that the identified organism was not sensitive to the Cipro.

The facility was cited at federal regulation F157 for not ensuring the physician was promptly notified to inform her of the laboratory results, as required.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #5:

The complainant stated the identified resident was started on an anti-anxiety medication after the resident refused to participate in physical therapy. The complainant stated the resident was unwilling to participate in therapy due to her low oxygen saturation levels. The complainant also stated the resident's responsible party "ordered" the staff to stop the medication but the facility refused to do so.

FINDINGS:

The identified resident's Occupational Therapy Progress Note, dated July 8, 2008, documented, "Pt (Patient) continues to improve in all areas... Pt has heightened anxiety (with) family present. Pt has requested med (medication) for anti-anxiety, nursing notified."

The resident's record documented the resident was alert, oriented and able to make her needs and requests known. Due to the resident's request, the nurse appropriately contacted the physician on July 8, 2008, and received an order for Xanax 0.5 milligrams by mouth to be administered daily at 9:30 a.m.

A Medication Consent form, dated July 8, 2008, documented the resident gave verbal consent to receive the anti-anxiety medication, Xanax. A staff member signed and initialed the form as witness to the verbal agreement by the resident.

The resident received Xanax 0.5 milligrams on July 8, 2008. The Interdisciplinary Progress Notes documented on July 8, 2008, "Spoke (with) Rsdt (Resident) (after) lunch stated she felt better (after) PT (physical therapy) (with) the new medication Xanax 0.5 mg (milligrams) (and) verbally stated that she is okay (with) using medication, witnessed by 2 RNs (registered nurses)... Initial dose of Xanax proved effective as therapist noticed decreased anxiety and increased participation..."

A nurses note, dated July 8, 2008, at 10:50 p.m., documented the resident's vital signs were stable, her oxygen saturation level was 89-91% on three liters of oxygen and she remained alert and oriented.

The next note, dated July 9, 2008, at 6:00 a.m., documented her vital signs were stable, that she received a pain medication at midnight and she slept during the night. The notes documented at approximately 10:15 a.m., her vital signs remained within normal limits and her oxygen saturation level was 93%. The note also documented that the resident's family member came into the resident's room about that time and told staff that she did not want the resident to have the Xanax. The nurse attempted to explain that the treating physician ordered the medication and it had been effective the previous day. The nurse documented, "This writer left room intent to get (name of Director of Nursing.) Upon returning visualized (family member) pulling away from facility in private car (with) (resident) sitting in front seat (with) her."

The nurse immediately notified the appropriate administrative staff and the treating physician that a family member had removed the resident from the facility, apparently against medical advice.

The resident's record documented that two of her family members had power of attorney, however, the resident, according to the hospital and facility records, was alert, oriented and able to make her needs known. The facility appropriately followed through on the resident's request for an anti-anxiety medication.

During interviews with the Director and Assistant Director of Nursing and the therapy manager, they confirmed the resident was alert and oriented and had requested an anti-anxiety medication to be given prior to her morning therapy sessions.

The Director of Nursing stated the resident received only two doses of the medication, Xanax, and had no adverse effects from the medication.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated that on the day the identified resident was admitted to the hospital, July 9, 2008, the staff started to remove the resident's belongings from her room, indicating that the resident had been discharged from the facility.

FINDINGS:

The identified resident's record documented that on July 9, 2008, at 10:15 a.m., the resident's family member came into the resident's room and stated, "I want (resident) sent to ER (Emergency Room) then another facility." Shortly afterward, the family member took the resident from the facility without notice.

The Social Worker's note, also dated July 9, 2008, documented the resident's family member called the facility later, "...to request referral information be faxed to (name of a care center) stating that resident

will be admitted to that facility per family arrangements. (Name of facility nurse) contacted (Name of Director of Nursing at care center) who confirmed that admission is anticipated for (Resident...)"

The final interdisciplinary note, dated July 9, 2008, at 3:20 p.m., documented, "...At 3 p.m., (family member) arrived and reviewed possession list (with) this nurse. All of resident's personal belongings removed from room & placed in (family member's) private vehicle. Resident d/c'd (discharged) from facility (with no) expectation for her returning to (facility.)"

According to the documentation, the facility appropriately removed the resident's belongings only after the resident's family member stated that the resident would not be returning to the facility. This was just prior to the family member removing the resident from the facility without notice.

The Assistant Director and Director of Nursing confirmed the events.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated the identified resident was sick for two weeks, with oxygen saturation levels dropping to the 70% levels and her blood pressure became low. On July 9, 2008, the resident's oxygen saturation level dropped to 65-75% and she became unresponsive. The facility did not respond to these medical changes, so a private vehicle transported the resident to a local hospital. Diagnoses included septicemia from pneumonia and urinary tract infection.

FINDINGS:

The identified resident's record documented she was admitted to the facility on May 21, 2008, after being hospitalized with diagnoses of repair of right hip fracture, chronic obstructive pulmonary disease, anemia, prolapsed bladder with indwelling Foley catheter, and pneumonia.

The record also documented that during the last two weeks of the resident's stay in the facility, including July 9, 2008, her condition was stable considering her multiple chronic diagnoses.

The Director of Nursing stated that when a family member removed the resident from the facility, the family member also removed a portable oxygen tank from the facility.

The resident was taken to the Emergency Room by private vehicle and without medical staff in attendance to monitor and document her vital signs, oxygen flow rate and oxygen saturation levels; therefore, there was no medical documentation to review from the time she left the facility until she arrived in the Emergency Room, approximately 20 minutes later.

The Emergency Room nursing notes, dated July 9, 2008, documented the resident arrived in the Emergency Room at 10:35 a.m. Her blood pressure = 118/63; pulse = 91; respirations = 22; temperature 100.0. She was placed on three liters of oxygen. There was no recorded oxygen saturation level. At 12:45 p.m., "...continues sedated. Awakens to verbal, oriented. 1300 (1:00 p.m.,) pt now awake and

conversing (with) family."

The Emergency Room physician's physical examination documented the resident's oxygen saturation levels ranged from 75 to 80 and at times rose to 86%. She was somnolent but able to be aroused.

The discharge summary, dated July 22, 2008, documented the resident had been admitted with recurrent pneumonia in the right lower lobe. While in the hospital, she also developed pneumonia in the left lobe, despite having been started on intravenous antibiotic therapy. As of July 21, 2008, she still had an infiltrate in the right middle lower lobe.

There was no documented evidence the resident had a urinary tract infection on admission to the hospital. According to the discharge summary her admission urinalysis was normal and a repeat test on July 15, 2008, documented her urine culture was negative.

There was no documented evidence the resident developed septicemia.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135021	A. BUILDING _____ B. WING _____	C 09/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON REHAB & CARE CENTER	3315 8TH STREET LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation survey of your facility. The surveyors conducting the survey were: Marcia Key RN, BSN, Team Cooridinator David Scott, RN Survey Definitions: MDS = Minimum Data Set Assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing RN = Registered Nurse LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record RD = Registered Dietitian	F 000	**This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.** RECEIVED OCT 20 2008 FACILITY STANDARDS	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	**Resident Specific** **The IDT (inter-disciplinary team) reviewed resident #1's laboratory reports for physician notification. The physician has been notified of all the reports.** **Other Residents** **The IDT reviewed other residents for proper physician notification of diagnostics. No other concerns were identified.** **Facility Systems** **Staff is educated for timely physician notification to include, but not limited to, faxing diagnostic reports. Re-education was provided related to physician notification and follow through on culture and sensitivity reports.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborra K. Hutchens	RN, DNS	10/16/2008

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on a complaint from the general public, interviews, and record review, it was determined the facility did not fax lab reports of urine culture to the resident's physician. The reports indicated a possible need for antibiotic therapy. This presented potential harm for 1 of 1 resident sampled (#1). Findings include: Resident #1 was admitted to the facility on 5/21/08 with diagnoses of right hip fracture aftercare, chronic obstructive pulmonary disease, anemia, pneumonia, and type II diabetes mellitus. The resident was admitted with an indwelling Foley catheter from a recent hospitalization. The resident was discharged from that hospital on 5/21/08. Resident #1's Bladder Elimination Management Care Plan, dated 5/21/08, documented the goal of, "Resident will be free of s/sx of UTI [signs or symptoms of urinary tract infection]," and the approach of, "Laboratory tests and studies as directed by the physician. Report results and	F 157	**Monitor** **The DNS (director of nursing services) and/or designee will review one resident weekly for timely physician notification and follow through related to diagnostics. The PI committee will discuss as indicated and may adjust the frequency of the monitoring, as it deems appropriate.** **Date of Compliance** **October 29, 2008** 10.28.08 called & asked facility about the monitor section only addressing 1 resident per ~~week~~ week. Admin faxed info see attached fax. km PDC accepted.	

PRINTED: 10/06/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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LEWISTON REHAB & CARE CENTER	3315 8TH STREET LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 follow new orders." The resident's record revealed she began to experience signs and symptoms of a urinary tract infection on 6/11/08. The physician was immediately notified and a urinalysis was ordered. A Physician Telephone Order, dated 6/11/08, directed staff to: "Send urine for C&S, Start Cipro 25 mg PO BID [Ciprofloxacin (antibiotic) 25 milligrams by mouth twice daily] for bladder infection for 7 days." The resident's record documented the urinalysis was obtained and the resident was started on the medication on 6/11/08. On 6/12/08, Resident #1's signs and symptoms of the urinary tract infection resolved and she had no further urinary problems during her stay in the facility. The facility received the results of the urine culture on 6/13/08, which documented the organism strain was resistant to the antibiotic. The facility did not receive an order to start a different antibiotic, Keflex, which the organism was sensitive to, until 6/20/08. On 9/24/08, at 12:15 p.m., the facility's Assistant Director of Nursing (ADON) was interviewed. The ADON indicated that from 6/11/08 to 6/18/08, Resident #1's anemia worsened, which prompted the physician and facility to focus their efforts on this more critical problem and the urine culture report was inadvertently overlooked. On 9/24/05, at 1:35 p.m., the facility's Resident Case Manager (RCM) was interviewed. The RCM stated the laboratory routinely sends all laboratory reports to the facility and to the physician's offices. During the complaint investigation survey, the laboratory faxed to the surveyors documented	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135021	A. BUILDING _____ B. WING _____	C 09/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON REHAB & CARE CENTER	**3315 8TH STREET LEWISTON, ID 83501**

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F 157	Continued From page 3 evidence that it had faxed the urine culture report to the physician on 6/13/08. On 9/24/05, at 2:30 p.m., the resident's physician was interviewed by telephone. The physician reviewed her office records and stated that, to her knowledge, she did not receive the faxed laboratory report. On 9/24/08, at 2:45 p.m., the facility's DON was interviewed and asked to explain the facility's policy for notifying physicians of laboratory reports. The DON provided surveyors with a copy of the facility's fax policy and stated the lab report is first faxed to the facility, which is in turn signed, dated, and then faxed to the physician. The DON stated the laboratory also faxes a copy of its report to the physician as well. Although the facility acted promptly after Resident #1 began to experience the signs and symptoms of a urinary tract infection and immediately started the ordered antibiotic, the facility failed to ensure the physician received the 6/13/08 urine culture report, or ensure the physician was aware that the identified organism was not sensitive to the ordered Ciprofloxacin antibiotic.	F 157		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON REHAB & CARE CENTER	3315 8TH STREET LEWISTON, ID 83501

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during a complaint investigation survey of your facility. The surveyors conducting the survey were: Marcia Key, RN, BSN, Team Cooridinator David Scott, RN Survey Definitions: MDS = Minimum Data Set Assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing RN = Registered Nurse LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record RD = Registered Dietitian	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation and Care Center does not admit that the deficiencies listed on the State Form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED OCT 20 2008 FACILITY STANDARDS	
C 173	02.100,12,d d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please refer to F157 as it relates to notifying a resident's physician of laboratory urinalysis reports.	C 173	Refer to the Plan of Correction at F157.	

Bureau of Facility Standards

Deborra K. Hutchens — TITLE: RN, DNS — (X6) DATE: 10/16/2008

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE